

DAY SUPPORT WAIVER

Day Support Individual Service Authorization Request

CSB _____

CSB provider # _____

Do NOT Use for MR Waiver

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Increase units/hours of service
 - ☐ Decrease units/hours of service
 - ☐ Procedure code modification (requires 2 ISARs)
- ☐ Provider modification (requires 2 ISARs)

Provider Name _____

Provider No. _____

Name: _____

Start: _____

End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED
ONLY

WEEKLY / MONTHLY UNITS

OMR USE

<input type="checkbox"/> 97537 Day Support, Reg Int. Center Based	<u> </u> Units / week	x 4.6 =	<u> </u>	<u> </u> Monthly Total 1
<input type="checkbox"/> 97537 U1 Day Support, High Int. Center Based				
<input type="checkbox"/> 97537 Day Support, Reg Int. Non Center				
<input type="checkbox"/> 97537 U1 Day Support, High Int. Non Center				
			+	
Enter Periodic Support units per month if needed – Do not include in hours/day below.	→			<u> </u> Monthly Total
			=	
Enter TOTAL of Periodic Support units + regular units per month.	→			<u> </u> Monthly Total 2

Reason for this request: _____

If High Intensity, check which criteria are met:

- ☐ Requires physical assistance to meet basic personal care needs
- ☐ Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals

- ☐ Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in programming. [A formal written behavioral objective is required to address behaviors such as self-injury or self-stimulation.]

Check the allowable activities that are included in the ISP:**Training in Functional Skills**

- ☐ self, social, environmental awareness
- ☐ sensory stimulation, gross/fine motor
- ☐ communication

- ☐ personal care
- ☐ use of community resources, safety
- ☐ learning and problem solving
- ☐ adapting behavior to social and community settings

Assistance and Supervision

- ☐ with personal care and use of community resources
- ☐ to ensure the individual's health and safety

- ☐ opportunities to use functional skills in community settings
- ☐ travel between activity and training sites

Record the number of hours per day of the following:

(for biweekly/ varied schedules, draw a line to indicate different weeks)

Total Hours of Program Time

(e.g., if individual is in program from 8 a.m. until noon, enter "4")

Travel with the individual to & from program:

[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) _____

Signature _____

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service modification has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print) _____

Signature _____

Phone No. _____

Fax No. _____

Date _____